FLOW RECORD INSTRUCTIONS

DST

Vitals

Record Monthly/Daily on Flow Record.
Use Vital Sign Record if vital signs are taken more frequently than daily.

Meals

For all residents record % of Meals/Snacks eaten.

G.I.

BM

Utilize code:

I- soft	M- medium
II- hard	L- large
X- liquid	XL- extra large

Last Void
Vomitus – Self Explanatory

Skin

Redness – Location, R- resolved, IPN Entry
Abrasion/Scratch – Location, IPN Entry
Bruise – Location, R- resolved, IPN Entry

Oral Care

Suction Tooth-brushing – Check mark for completion
Oral Swab – Check mark for completion

Nurse

Vitals

If O2 Sat is taken more than once a day, utilize IPN/MAR.

BM

Suppository – Y or N
Enema – F- Fleets, SS- Soap Suds
Chart results in IPN, as well as on Flow Record.

Skin

Other – Chart location on Flow Record and document in IPN if a skin breakdown is noted. Documentation to occur until Resolved (R) with IPN entry.

G-Tube

Formula – Identify type of feeding and amount
Residual – Amount: if ↑ 25cc chart in IPN
Site Care – Y/N: if redness or drainage present, chart until Resolved (R) with IPN entry.

Evening Nurse

Must initial each Flow Record after review data. Do appropriate follow-up as indicated.